SIM LHIC Stakeholder Meeting

July 16, 2013

Stakeholder Feedback To Date

Feedback: Primary Care Providers

- Confusion among primary care physicians about what they can and cannot “join” – e.g. ACO versus PCMH
- Primary care physicians not on EMRs concerned re: ability to export quality metric data automatically.
- Need to receive timely actionable data that is in the same format for all patients

Feedback: Payment Model

- Very difficult to identify the savings generated exclusively by this program.
- "The savings estimates are not a reliable source of long term funding."
  - "As the model is proven to work and becomes the norm, the variation in costs between different primary care providers will lessen and additional incremental savings will diminish. "
- Pay for service with real $ up front.
  - Steep discount in year 1
  - Evaluation early so can incent payers to continue paying for service
  - ROI—what can we guarantee?

Feedback: Implement the model incrementally

- ID target population
- Address concerns re: availability of CHW
- Performance targets
  - risk adjustment at the community level to accommodate differences in patient populations
- Address concerns about mandates to participate
- Build trust and a high functioning relationship between primary care providers and the Local Health Improvement Coalitions

Feedback: Metrics

- Quality metrics and financial parameters should be the same for all patients.
- Quality metrics should be easy to obtain (EMRs, Claims data)
- Include ER metrics
- Additional requirements and evaluation measures without supportive funding is a concern
- Tier metrics based on sophistication of practice
- The importance of community-based metrics (the metrics proposed so far have been clinically-focused)
- Performance of the entire population and not just those enrolled in a participating PCMH

Feedback: Patient Attribution

- Methodology must be transparent
- Establish systems to adjudicate attribution lists, quality metrics and medical costs.

Feedback: CHW

- Practices will benefit financially from the services of a well-trained and monitored team of CHWs deployed geographically
  - not have to recruit, hire, train and monitor
- Embedded vs not embedded
- Scalability
- How will their role overlap with CM

Feedback: LHIC

- Educate and promote provider engagement in LHIC efforts
  - reinforce the value of this model in community health improvement
- Demonstrate the value added of community integrated interventions
- Guide data integration across systems
- Providing a connector to state and local initiatives—demonstrating that local and state health goals are aligned
- Scalability
- Certification

Feedback: Duplication of Services

- “Everyone wants to do care management – insurers, health departments, hospitals, and PCPs”
- Increased amount of unreimbursed work
- Ability to sustain care management services in a PCP offices

Feedback: Other

- How do you bring in Self Insured plans?
- Palliative Care
- Implementation of MOLST community wide
- Call center

Questions or Comments?

Update:
CHW Workforce Development Technical Assistance and CIMH Readiness

Workforce Development and CIMH Readiness

- Conduct background research to inform Community Health Worker development
  - √ Inventory of training programs and CHW models
  - √ Identify best practices for integration of CHW into medical practices and broader health care system
  - √ Will present findings at LHIC stakeholder engagement process

- Technical assistance and CIMH readiness
  - Identify various ongoing TA and develop recommendation for streamlining
  - Convene TA providers and chart path forward
  - Identify and describe quality improvement efforts in local communities
  - Assist in scaling up of promising QI models

CHW Workforce Development

- White paper development
  - Literature review of effective CHW models and best practices for integration of CHW into medical practices and broader health care system
  - Key informant interviews with state and national experts
  - Maryland CHW program survey

- Key constituent meeting to obtain feedback on the role(s) of CHW and the necessary infrastructure to support the CHW role

Key Informant Interviews

- Environmental scan of selected existing CHW programs in Maryland
- 16 key informant interviews
- Continuum of roles and functions of what was identified as “community health worker”
- Represented a cross section: of organizations:
  - Community
  - County level
  - Medical
  - Volunteer and paid CHWs workers
  - Training and supervisory approach.

Types Organizations Interviewed

- FQHC
- Faith based
- Race & Ethnic based community
- Local health department
- Hospital systems
- Low income insurer
- Federal government agency
- AHEC
- Behavioral health

Key Informant Interviews

Major Themes:

1) Funding for sustainability

2) Focus on services to a disease or disparate populations and ethnic groups

3) How will organizations with limited resources measure results

4) Focus on client empowerment and self-management

5) Cultural sensitivity in design of programs and development of program procedures

Scope of Services of "CHW" Organizations

- Client/population empowerment and self-management

- Providing of a wide variety of healthy opportunities for self- improvement, access to resources, transportation, and adherence/check-ins in peer based / community based models

Key Informant Interviews

- JACQUES Initiative (Joint AIDS Community Quest for Unique and Effective Treatment Strategies) combination of support, advocacy, and a drive for clients impacted by HIV to live well by receiving early treatment from an expert multidisciplinary team while living in a broader community that is fully engaged in HIV prevention, care and support.

- Way Station is a three-county health home pilot that created comprehensive health home for 1000 adults with severe and persistent mental illness in Frederick, Howard and Washington counties.

- J-CHIP: targets highest risk Medicare and Priority Partners Medicaid patients who receive primary care within the 7 zip codes in Baltimore city. This program is integrated into primary care with robust communication strategy and data driven patient centered interventions. Care manager supervised quality improvement and, evaluation process is built into program design.

Key Informant Interviews

- Garrett County Health Department : the purpose of the program is to enhance perinatal maternal and child outcomes, including home one on one- safety, smoke detector use, car seats, bike helmet, housing, breast feeding.

- Project HEAL is based on extensive experience in CHW training through faith based recruitment in Prince George's County churches and offers volunteer CHWs an opportunity to become trained and certified in an evidence-based rigorous curriculum including 13 educational modules. Volunteer CHW are supervised in all field work and evaluation utilized to assess outcomes.

- Healthy Howard: CHW are drawn from the community and every health plan registrant is offered an opportunity to avail of CHW services by opting in. CHW establish patient directed goals and meet with clients on a regular basis while being supervised by a RN. Patient outcomes are rigorously measured and tracked.

CHW Program Key Constituents Meeting

Purpose: to engage leaders with experience in planning or administering CHW programs to inform the planning and design of the CIMH intervention.

Participants: 26 organizations (6 of which are LHIC stakeholders)

Questions:

1. *What are the characteristics and skills of an effective CHW?*
2. *What are the critical components of a successful CHW program? (training, supervision, data tracking, evaluation)*
3. *What is the state infrastructure required to support a CHW workforce? (standards, certification, financing)*

CIMH Design Questions that will inform the CHW Workforce Development

- What is the linkage / connection between primary care and LHIC?
- What is the role of the LHIC in oversight, supervision and deployment of the CHW?
- What is the scope of practice for the CHWs?
- Are CHWs embedded in practices or part of a community based organization or local health department/LHIC or other?

Questions or Comments?

Payment Model

Payment Model for Community-Based Intervention

- Like a public utility, all those deriving benefit from the operation of the CIMH would help pay for it
- Risk-adjusted per capita surcharge levied on payers to cover cost of the intervention
- Medicare currently pays for HQP's community-based intervention using a similar approach

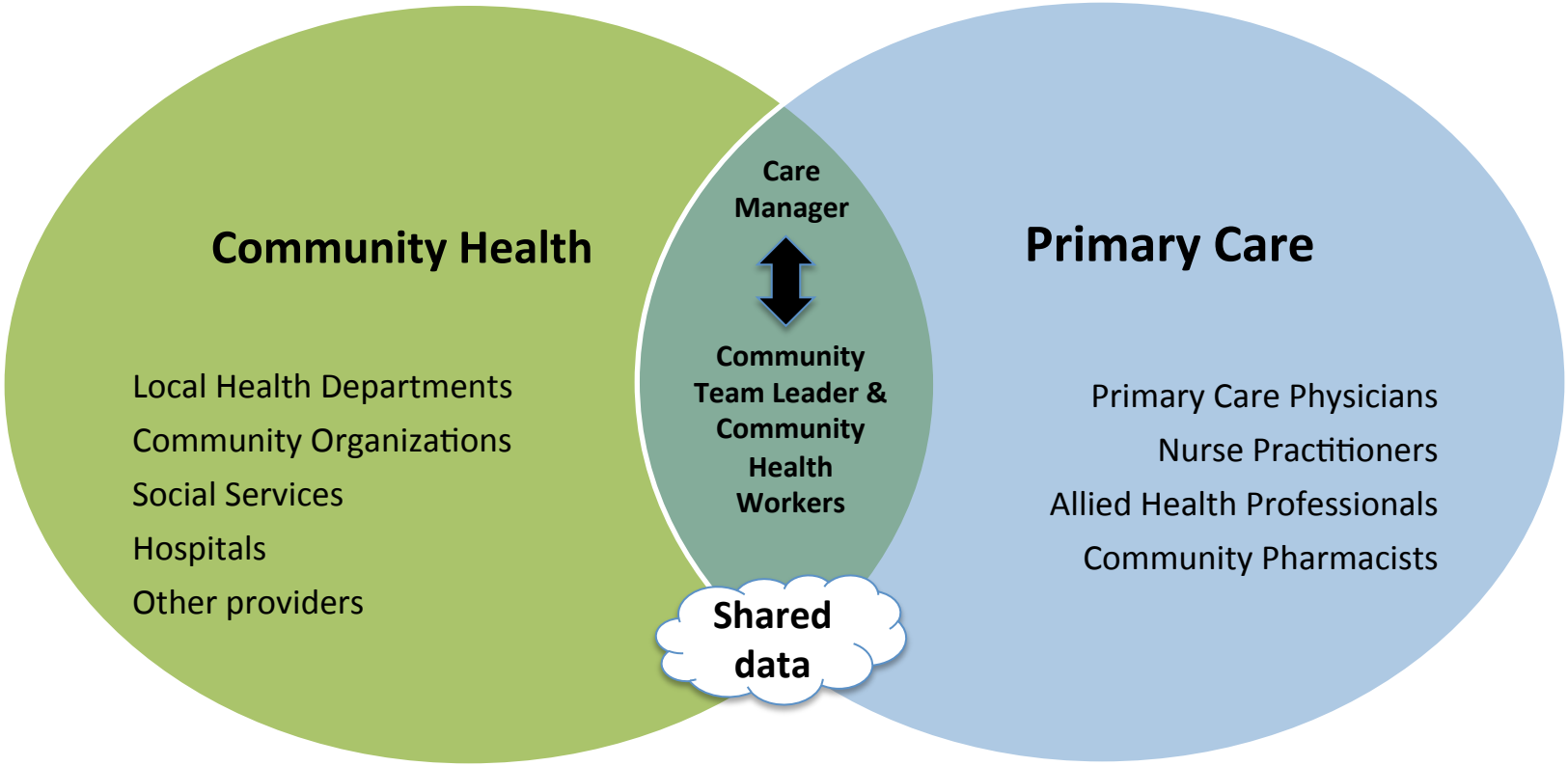
Medicare Payment for APS

Estimates of Magnitude and Reach: HQP's APS Model Applied to Maryland	
Pop. Descr.	>= 65 yrs with HF, CHD, DIAB and/ or COPD and 1+ hosp. adm. in prior yr.
Pop. Size	Est. 15-20% of Medicare population • counts for LHICs TBD; • State ≈ 129,000 [1]
Intervention	HQP Advanced Preventive Service
Care team composition and reach	nurse care manager (1 to 75 persons)
Intervention Cost	Est. $150 – $220 PPPM
Total $ Savings	$1,320 - $3,960 PPPY x number of participants enrolled = annual savings
ROI	Est. 50-150%

Medicare currently pays for the APS community-based intervention using a severity-adjusted per person per month fee

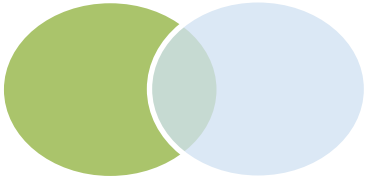
Public Utility

Community-Integrated Medical Home



Public Utility Core Functions

Community-Based	Practice-Based
• Certification of Local Health Improvement Coalitions • Performance measurement & feedback at the *population-level* • Oversight of community-based services – Quality assurance metrics – Standards and training for community health workers	• Certification of practices • Performance measurement & feedback at the *practice-level* • Oversight & monitoring – patient attribution: a virtual common roster – Validation of payer or practice-generated aggregate data



Governance & Staffing

A method or process for exercising control, authority, or management

Accountability for actions taken to achieve an aim

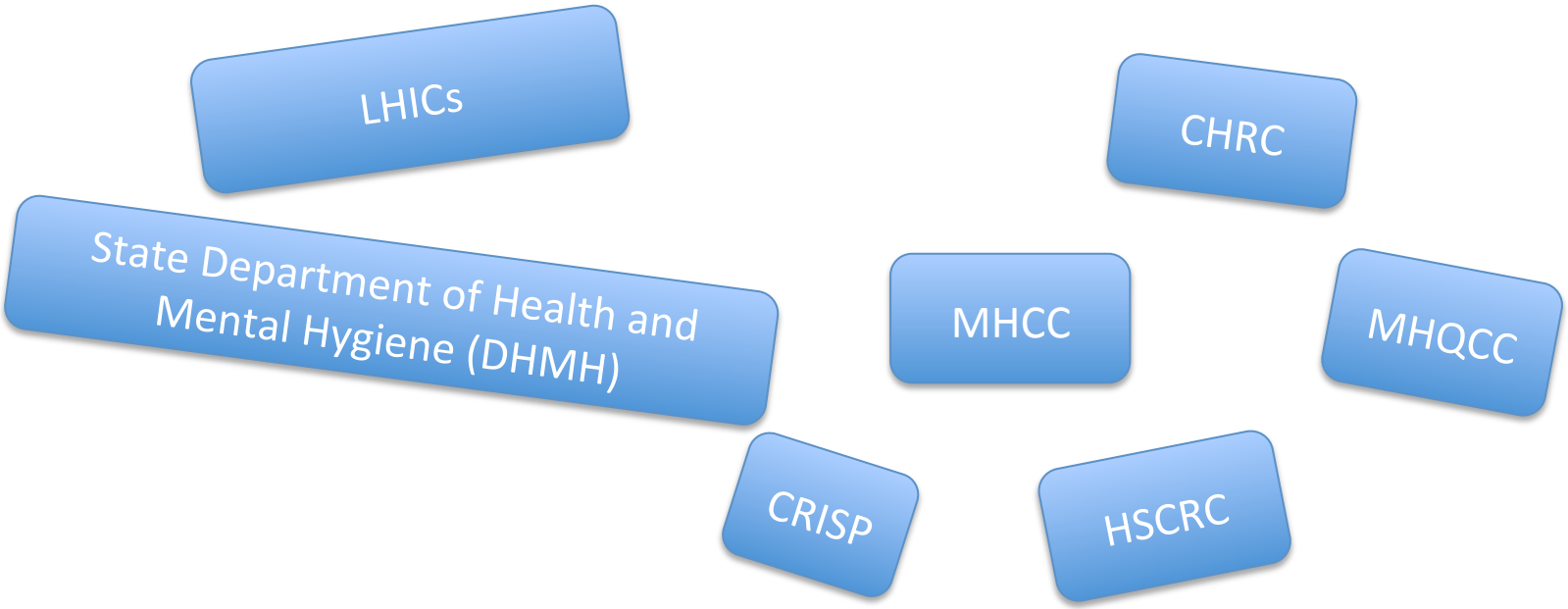
Governance & Staffing

- Several dimensions to a large complex undertaking such as the CIMH model
  - Location
    - State and Local
  - Elements
    - Strategic
    - Financial
    - Operational
    - Aspirational

ADDING TO BOTH THE COMPLEXITY AND POSSIBILITY:

- Many key Maryland resources will contribute to a successful CIMH model.
- These resources must be coordinated and aligned by means of a governance 'framework'.

Arrange these assets (and/or others?) to achieve an effective CIMH governance framework



LHICs – Local Health Improvement Coalitions
MHCC – Maryland Health Care Commission
MHQCC – Maryland Health Quality and Cost Council
HSCRC – Health Services Cost Review Commission
CHRC – Community Health Resources Commission
CRISP – Chesapeake Regional Information System for Patients

Effective, reliable, and adaptive implementation of Community Health Interventions 'on the ground'

Policies, data flows, financing, and PCMH measurement and support enabling CIMH system success

Governing Body: New Entity or Modification of Existing

Public Utility

Community-Based

- Certification of Local Health Improvement Coalitions
- Performance measurement & feedback at the population-level
- Oversight of community-based services
  - Quality assurance metrics
  - Standards and training for community health workers

Practice-Based

- Certification of practices
- Performance measurement & feedback at the practice-level
- Oversight & monitoring
  - patient attribution: a virtual common roster

Option #1 – New Entity & Staffing

- Create a new entity modeled after corporate/governance structure of state's Health Benefit Exchange
- A public corporation and a unit of state government with new and separate staff
  - Adhering to *selected* sections of the State Finance and Procurement Article
- Board (as configured for the Benefit Exchange; by way of example)
  - Secretary of Health and Mental Hygiene
  - Commissioner
  - Exec Dir of MHCC
  - Appointed by the Governor with advice and consent of Senate
    - 3 members representing interests of employers and individual consumers
    - 3 members with expertise in health insurance (incl purchasing and enrollment), health care financing, public health
  - Board Chair designated by the Governor
- Exec Dir selected by the Board with Governor approval
  - Structure provides greater hiring and contracting flexibility
- Specified Advisory Committee and stakeholder engagement

Option #2 – Build on Existing Capacity

DHMH Secretary
Deputy Secretary for Public Health

Governor-Appointed Commissioners

Health Systems and Infrastructure Administration
Office of Population Health Improvement
Office of Workforce Development

Maryland Health Care Commission

Public Utility

Community-Based

- Certification of Local Health Improvement Coalitions
- Performance measurement & feedback at the population-level
- Oversight of community-based services
  - Quality assurance metrics
  - Standards and training for community health workers

Practice-Based

- Certification of practices
- Performance measurement & feedback at the practice-level
- Oversight & monitoring
  - patient attribution: a virtual common roster

Governance Organizations

Acronym	Name	Composition	Description
MHCC http://mhcc.dhmh.maryland.gov/SitePages/Home.aspx	**Maryland Health Care Commission** Created 1999 Comprised of 5 Centers; • Hospital Services • Long-Term and Community-Based Care • Health Care Financing and Health Policy • Information Services and Analysis • Health Information Technology	15 members appointed by the Governor with the advice and consent of the Senate	An independent regulatory agency whose mission is to plan for health system needs, promote informed decision-making, increase accountability, and improve access in a rapidly changing health care environment by providing timely and accurate information on availability, cost, and quality of services to policy makers, purchasers, providers and the public. The Commission's vision for Maryland is to ensure that informed consumers hold the health care system accountable and have access to affordable and appropriate health care services through programs that serve as models for the nation. MHCC provides oversight and analytic support for Maryland's current PCMH initiatives – both the carrier-specific programs and the multi-payer program.
HSIA http://hsia.dhmh.maryland.gov	**Health Systems and Infrastructure Administration** Created 2012 Comprised of 3 Offices • Office of Population Health Improvement • Office of Primary Care Access • Office of School Health Oversees core funding of local health departments Serves as governing body for Maryland's 2 chronic care hospitals	Housed within DHMH and reports to the Deputy Secretary for Public Health	The Administration was created in 2012 in anticipation of health reform implementation and to focus efforts on population-wide health improvement through greater alignment and integration of public health and medicine. The Administration houses the Office of Population Health Improvement (which oversees the 18 Local Health Improvement Coalitions through the State Health Improvement Process). The Local Health Improvement Coalitions are, in turn, locally governed and typically co-chaired by a local health department health officer and hospital/health care executive. The Administration also houses the Office of Workforce Development (within the Office of Primary Care Access).

Questions or Comments?

CRISP

Connecting Physicians With Technology to Improve Patient Care in Maryland

Chesapeake Regional Information System for Our Patients

CRISP Overview

SIM and LHIC Meeting

July 16th, 2013

7160 Columbia Gateway Drive,
Suite 230
Columbia, Maryland 21046
1.877.95.CRISP (27477)
www.crisphealth.org

CRISP Mission and Vision

Mission

To advance the health and wellness of Marylanders by deploying health information technology solutions adopted through cooperation and collaboration.

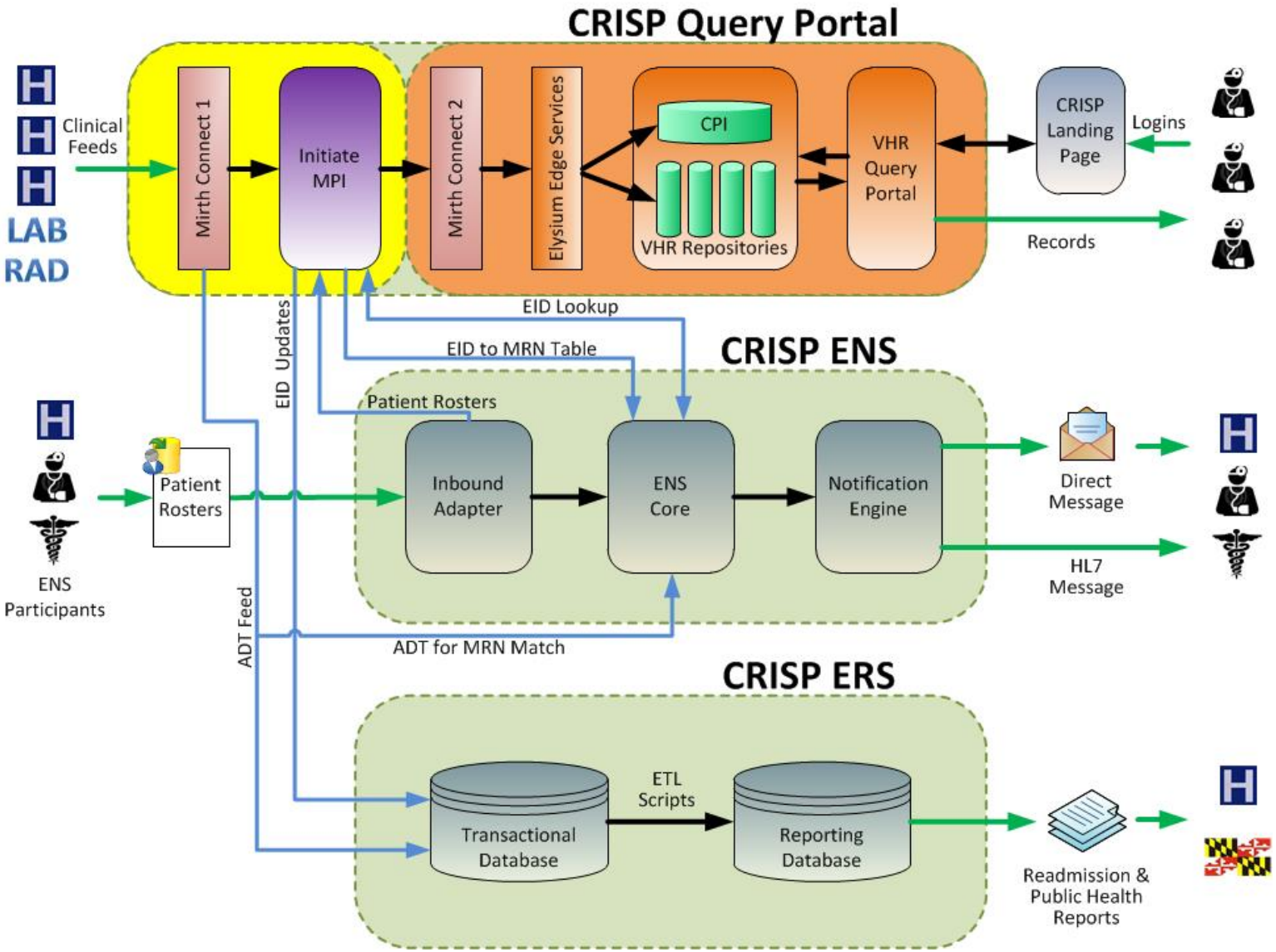
Vision

We will enable and support the Maryland healthcare community to appropriately and securely share data in order to facilitate care, reduce costs, and improve health outcomes.

Numbers at a Glance

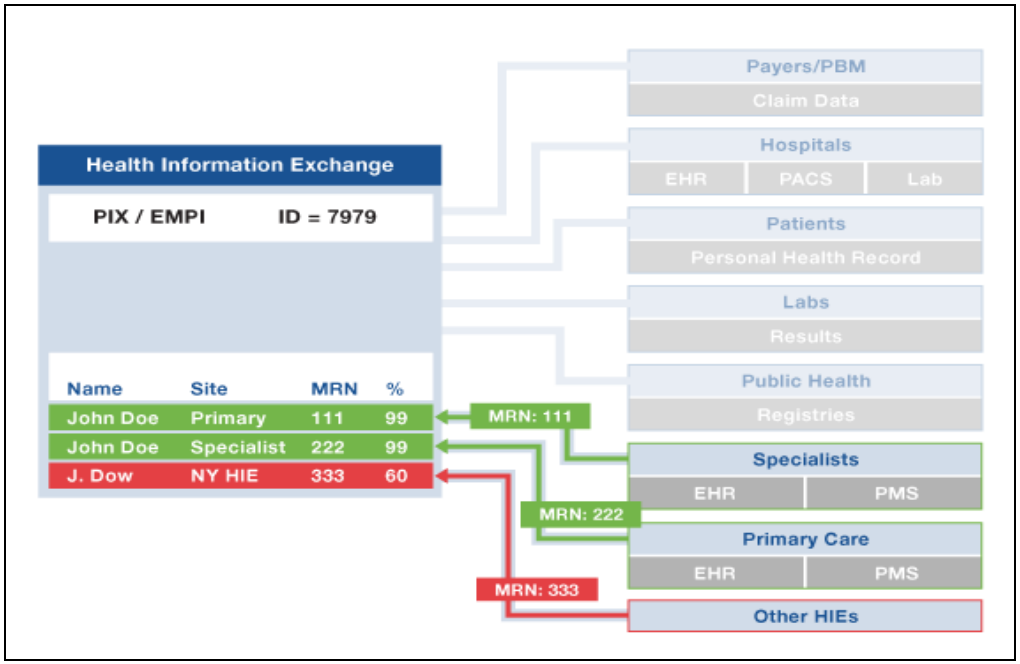
Progress Metric	May '13
Live Hospitals	47
Live Labs and Rad Centers (non-hosp)	9
Live Clinical Data Feeds	98
Identities in MPI	~5.4M
Lab Results Available	~29M
Radiology Report Available	~8M
Clinical Documents Available	~4M
Opt-Outs	~2,000
Queries (past 30 days)	~14,000
Notifications (past 30 days)	~60,000
Participating physicians (query & notification)	~1,200

Technical Architecture Overview



Patient Identity Management

Chesapeake Regional Information System for Our Patients



The Challenge:

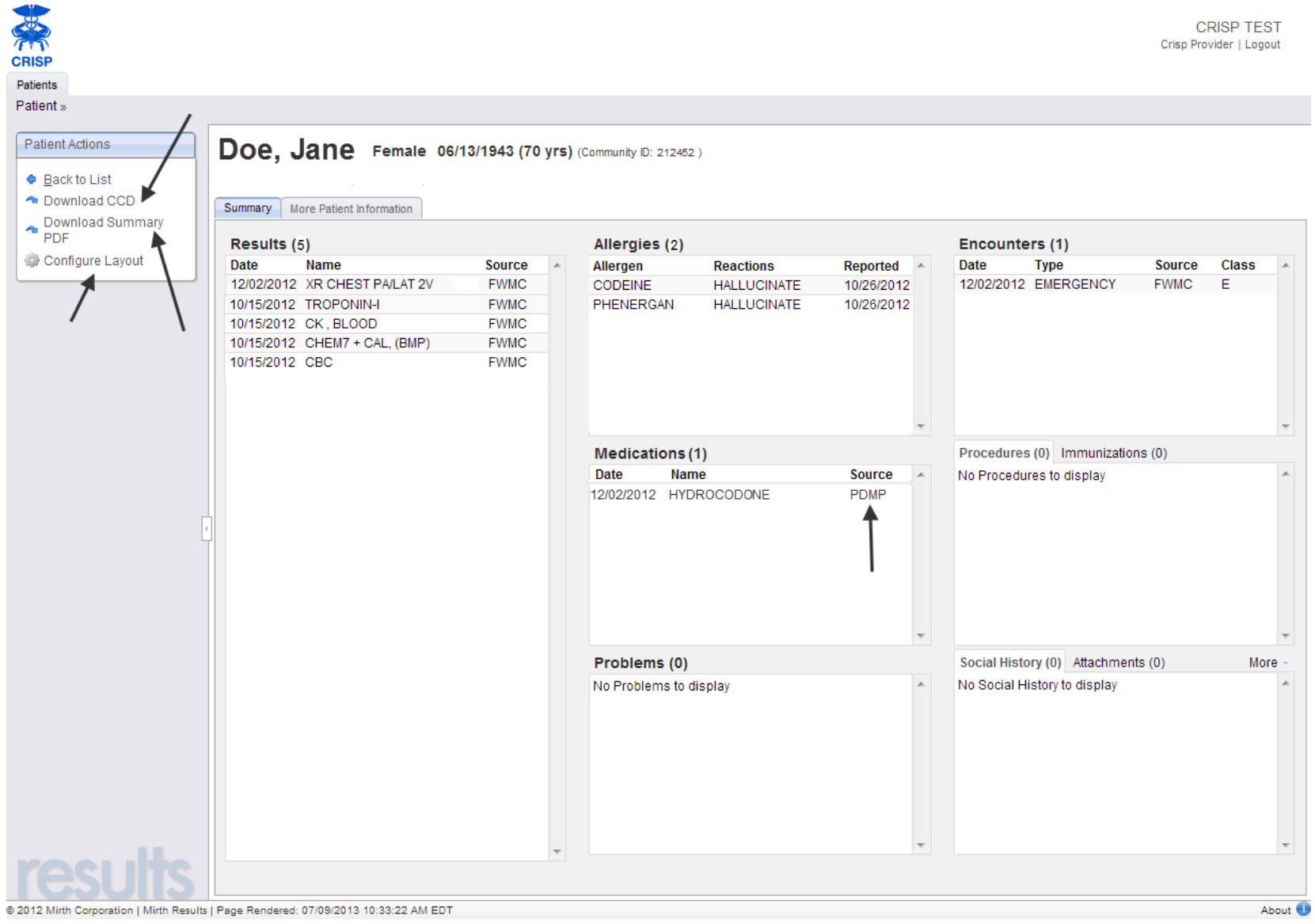
Accurately and consistently linking identities across multiple facilities to create a single view of a patient.

A near-zero tolerance of a false positive match rate with a low tolerance of a false negative match rate.

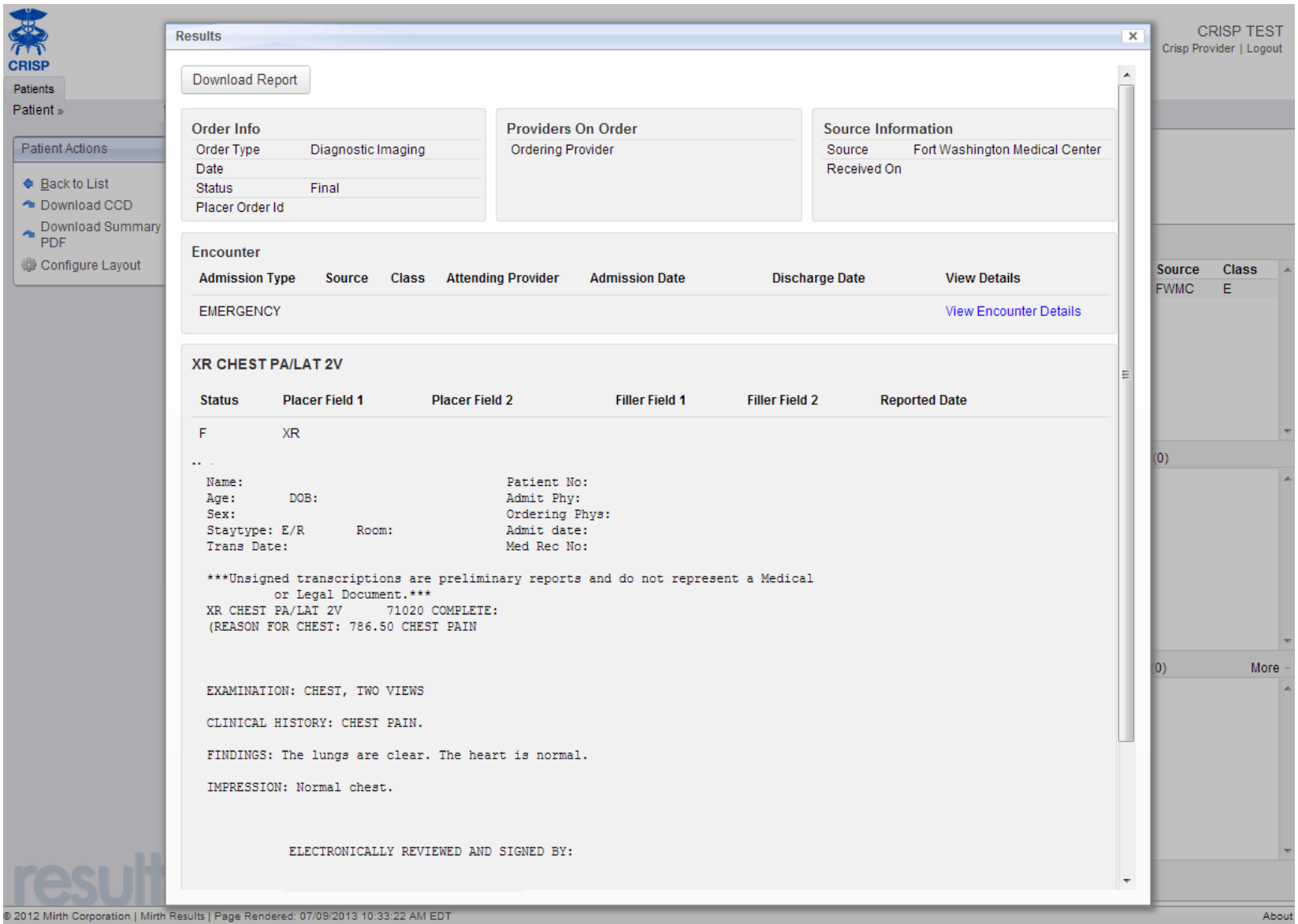
Accurate cross-entity patient identity management is a fundamental requirement for population-level measurement, utilization trending, and care coordination.

Query Portal - Mirth

Chesapeake Regional Information System for Our Patients



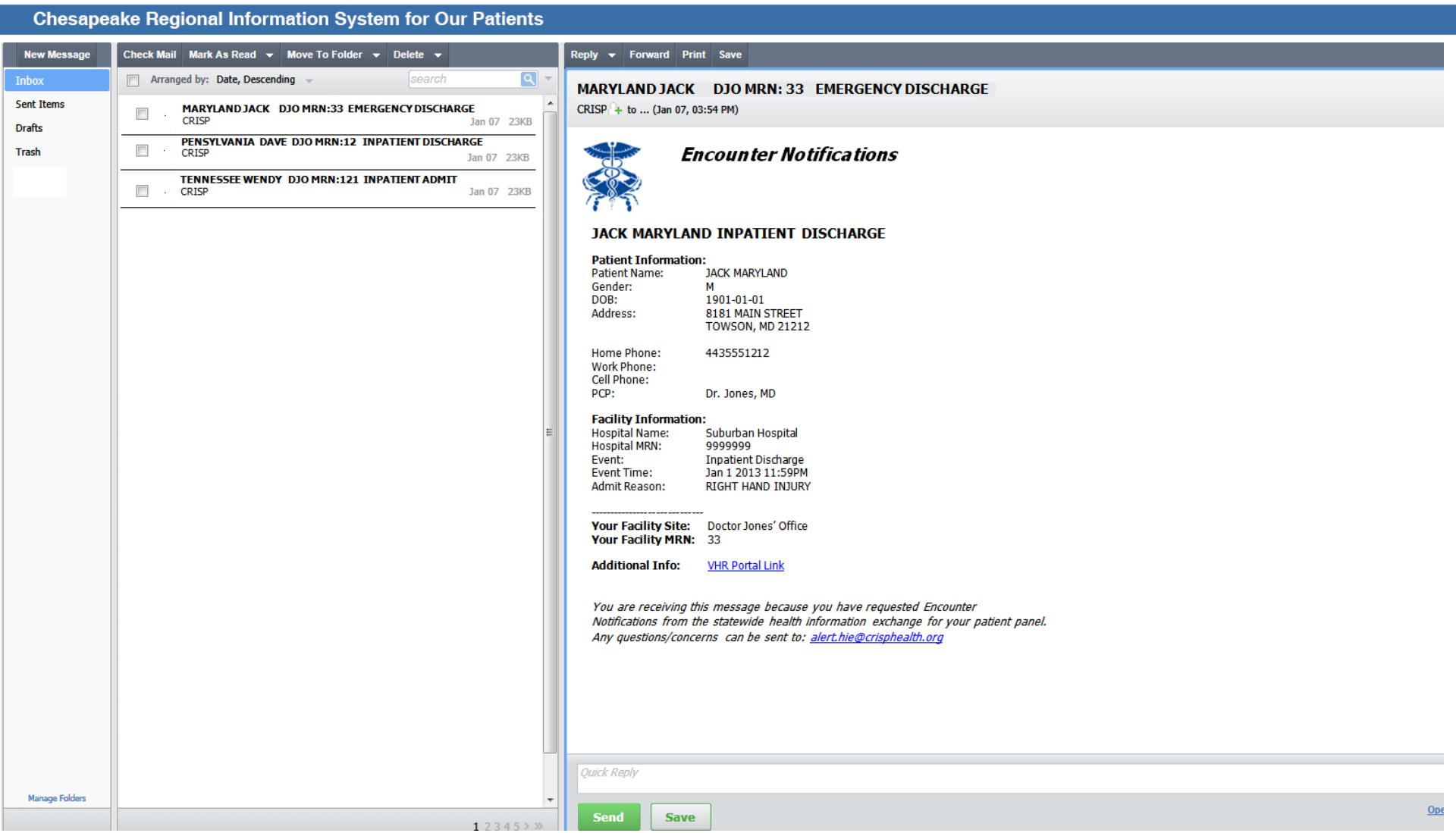
Query Portal - Mirth



Encounter Notification Service

- ENS enables CRISP participants to receive real-time notifications when one of their patients or members is hospitalized.
- The alerts are generated from the “ADT” messages CRISP receives from all Maryland hospitals.
- Participants can only subscribe to “active patient or members”
- If an individual has opted out of the HIE, an alert will not be triggered.
- There are currently over 1,000,000 patients subscribed to with in ENS resulting in over 2,000 notifications per day.

ENS Inbox Sample View



ENS Subscriber Sites

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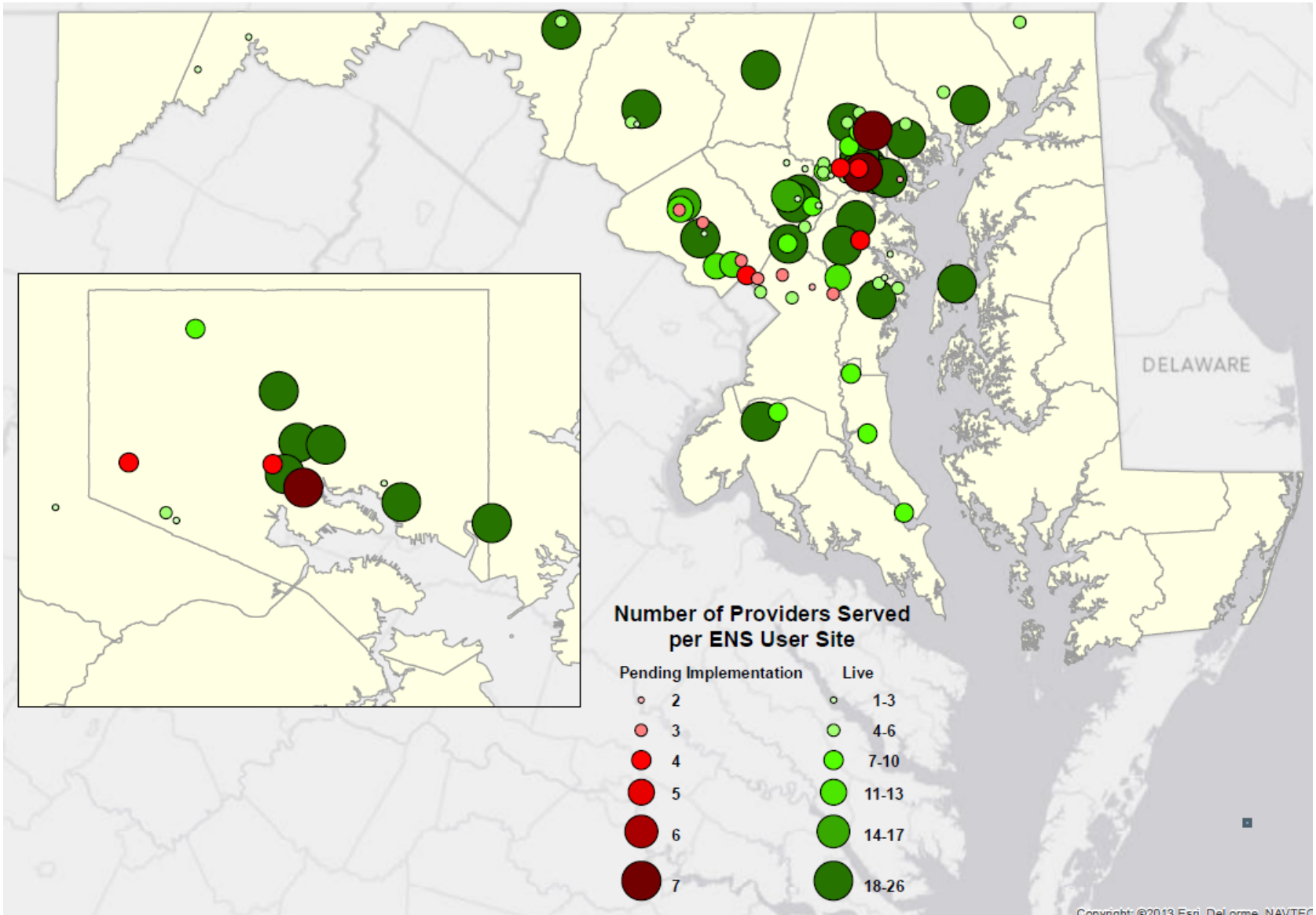

Individual Subscription by County

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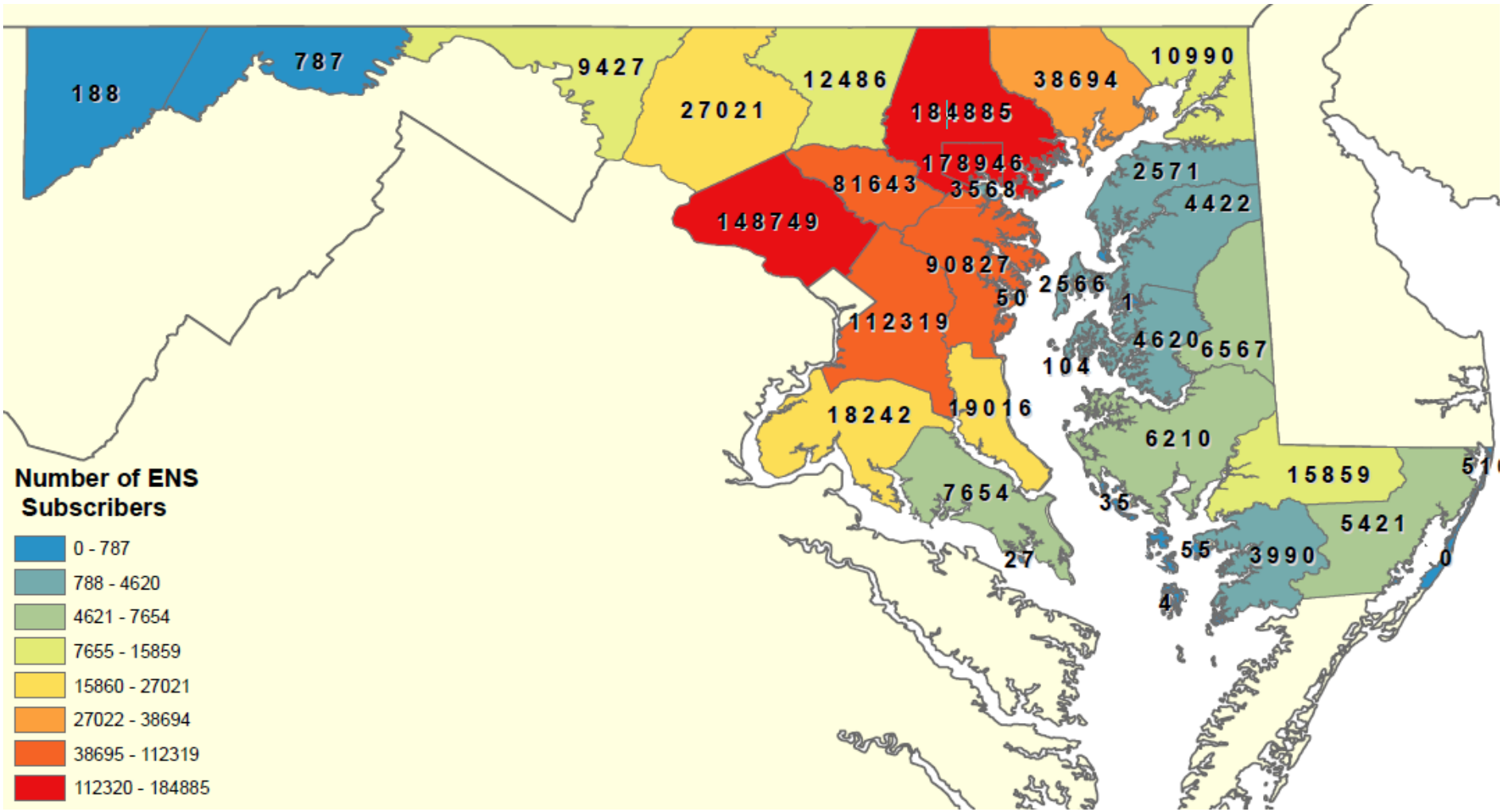


Maryland SIM Program and CRISP's Role

- DHMH and CRISP have partnered under Maryland's SIM Model Design Grant to develop a hospital service utilization reporting and mapping capability (building from the existing Encounter Reporting Service).
- Reporting and mapping capabilities will be designed to support the community integrated medical home model that is core to the Maryland approach.
- CRISP reporting and mapping capability will be enhanced to support broader "Camden Initiative-like" capabilities on a statewide scale.
- Additional data types will be incorporated into the CRISP reporting solution to enable broad understanding of population health status and trending.
- Highly granular mapping and reporting will be made possible through CRISP's address level data for encounters.

Hospital Services Utilization Reporting

- As encounter messages flow into CRISP, reporting on aggregate hospital services, regional or community utilization, and trending analysis becomes possible.

- By consolidating, correlating, and reporting against real-time encounter data CRISP can produce rapid and comprehensive views of hospital data for purposes such as identifying (to the appropriate entity) “super-utilizers” in targeted geographies.

HEZ IP Utilization (ALL) January to March 2013

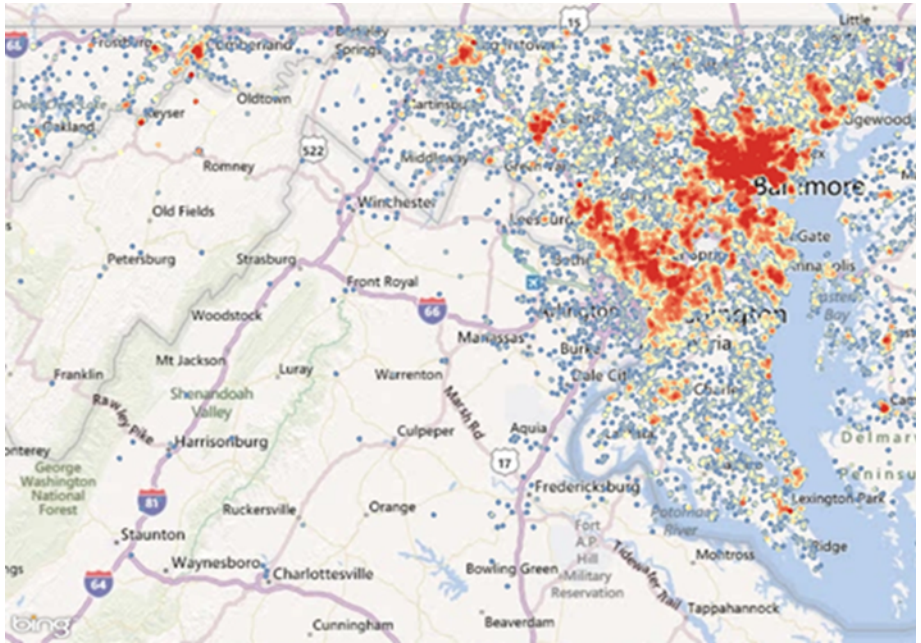
Chesapeake Regional Information System for Our Patients

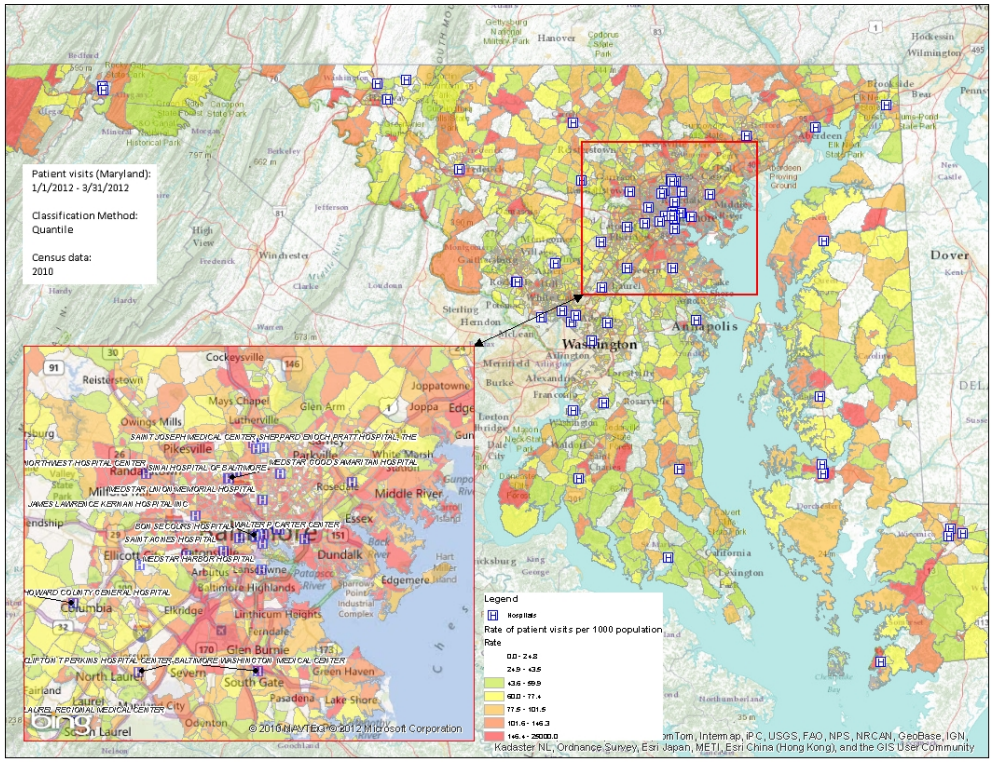
Description	Zipcode	2010 Census Population	Jan-Mar 2013 # Patients	Jan-Mar 2013 # Discharges	Jan-Mar 2013 # Basic Readmits	Jan-Mar 2013 Total LOS Days	Visits per Patient	Readmits per Patient	Readmits per Discharge	LOS per Patient	LOS per Visit	% HEZ Discharges Discharges Zipcode/HEZ	% HEZ Readmits Readmits Zipcode/HEZ
Annapolis		36,012	1,063	1,266	569	5,437	1.19	0.54	0.45	5.11	4.29		
Annapolis	21401	36,012	1,063	1,266	569	5,437	1.19	0.54	0.45	5.11	4.29		
Bon Secours		140,761	5,774	7,247	4,789	34,449	1.26	0.83	0.66	5.97	4.75		
Bon Secours	21216	32,071	1,332	1,639	927	7,886	1.23	0.70	0.57	5.92	4.81	23%	19%
Bon Secours	21217	37,111	1,590	2,024	1,431	9,499	1.27	0.90	0.71	5.97	4.69	28%	30%
Bon Secours	21223	26,366	1,276	1,649	1,181	7,785	1.29	0.93	0.72	6.10	4.72	23%	25%
Bon Secours	21229	45,213	1,576	1,935	1,250	9,279	1.23	0.79	0.65	5.89	4.80	27%	26%
Dorchester		34,990	1,103	1,271	413	5,266	1.15	0.37	0.32	4.77	4.14		
Dorchester	21613	17,330	635	735	265	3,075	1.16	0.42	0.36	4.84	4.18	58%	64%
Dorchester	21631	2,731	74	79	12	288	1.07	0.16	0.15	3.89	3.65	6%	3%
Dorchester	21632	6,353	155	182	53	743	1.17	0.34	0.29	4.79	4.08	14%	13%
Dorchester	21643	5,979	183	209	61	871	1.14	0.33	0.29	4.76	4.17	16%	15%
Dorchester	21659	1,551	19	25	14	120	1.32	0.74	0.56	6.32	4.80	2%	3%
Dorchester	21664	539	23	26	4	91	1.13	0.17	0.15	3.96	3.50	2%	1%
Dorchester	21835	507	14	15	4	78	1.07	0.29	0.27	5.57	5.20	1%	1%
Prince Georges		38,621	774	920	455	4,025	1.19	0.59	0.49	5.20	4.38		
Prince Georges	20743	38,621	774	920	455	4,025	1.19	0.59	0.49	5.20	4.38		
St. Mary		30,902	621	615	1,644	2,199	0.99	2.65	2.67	3.54	3.58		
St. Mary	20634	5,927	117	133	36	373	1.14	0.31	0.27	3.19	2.80	22%	2%
St. Mary	20653	24,481	490	467	1,608	1,796	0.95	3.28	3.44	3.67	3.85	76%	98%
St. Mary	20667	494	14	15	0	30	1.07	0.00	0.00	2.14	2.00	2%	0%

GIS Mapping Capability

Chesapeake Regional Information System for Our Patients

- Based on the indexed utilization information CRISP can produce visualizations of hospital utilization data in near real time.
- CIMH can leverage geographic data to better understand localized use of services and opportunities for the most efficient / targeted interventions.

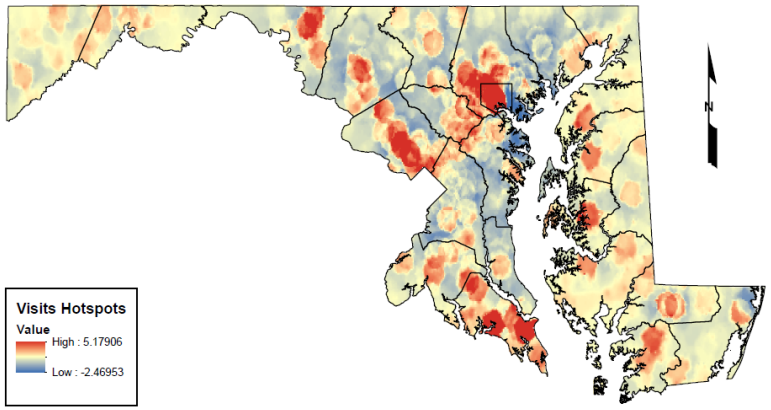




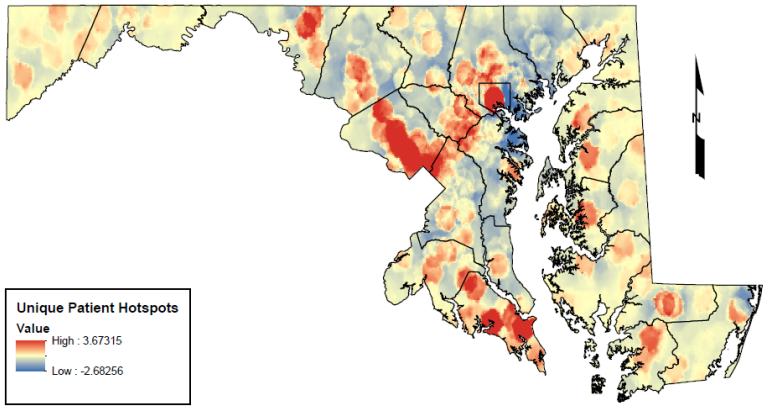
GIS Mapping Capability

Chesapeake Regional Information System for Our Patients

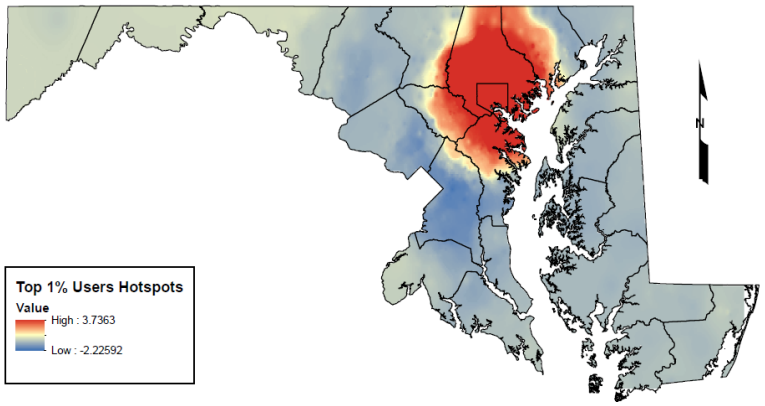
Visits



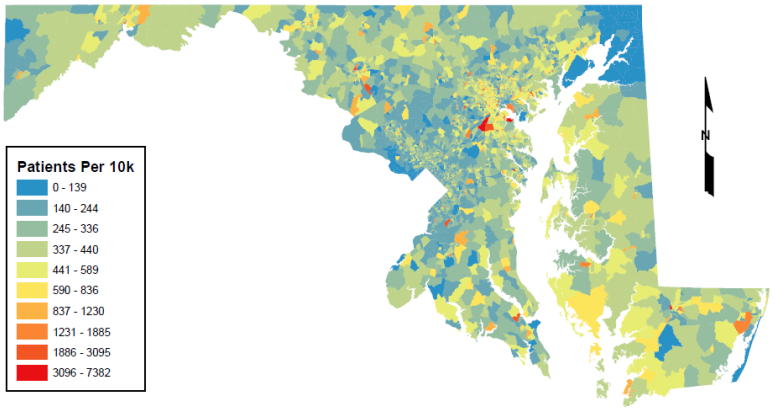
Unique Patients



Top 1% Patients

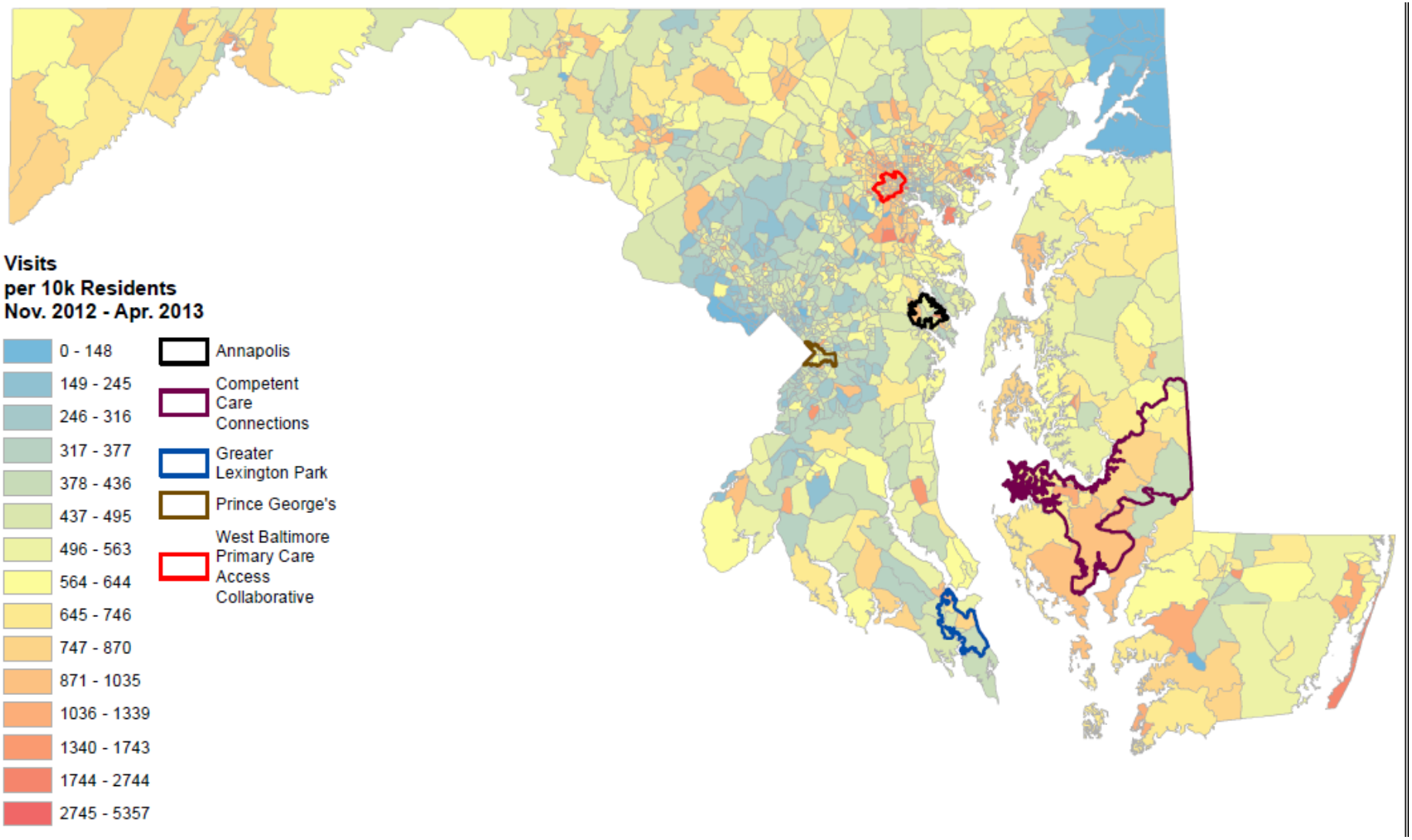


Unique Patients Normalized by Population



IP Utilization by Census Tract - Visits

Chesapeake Regional Information System for Our Patients



IP Utilization by Census Tract – Prince George's County

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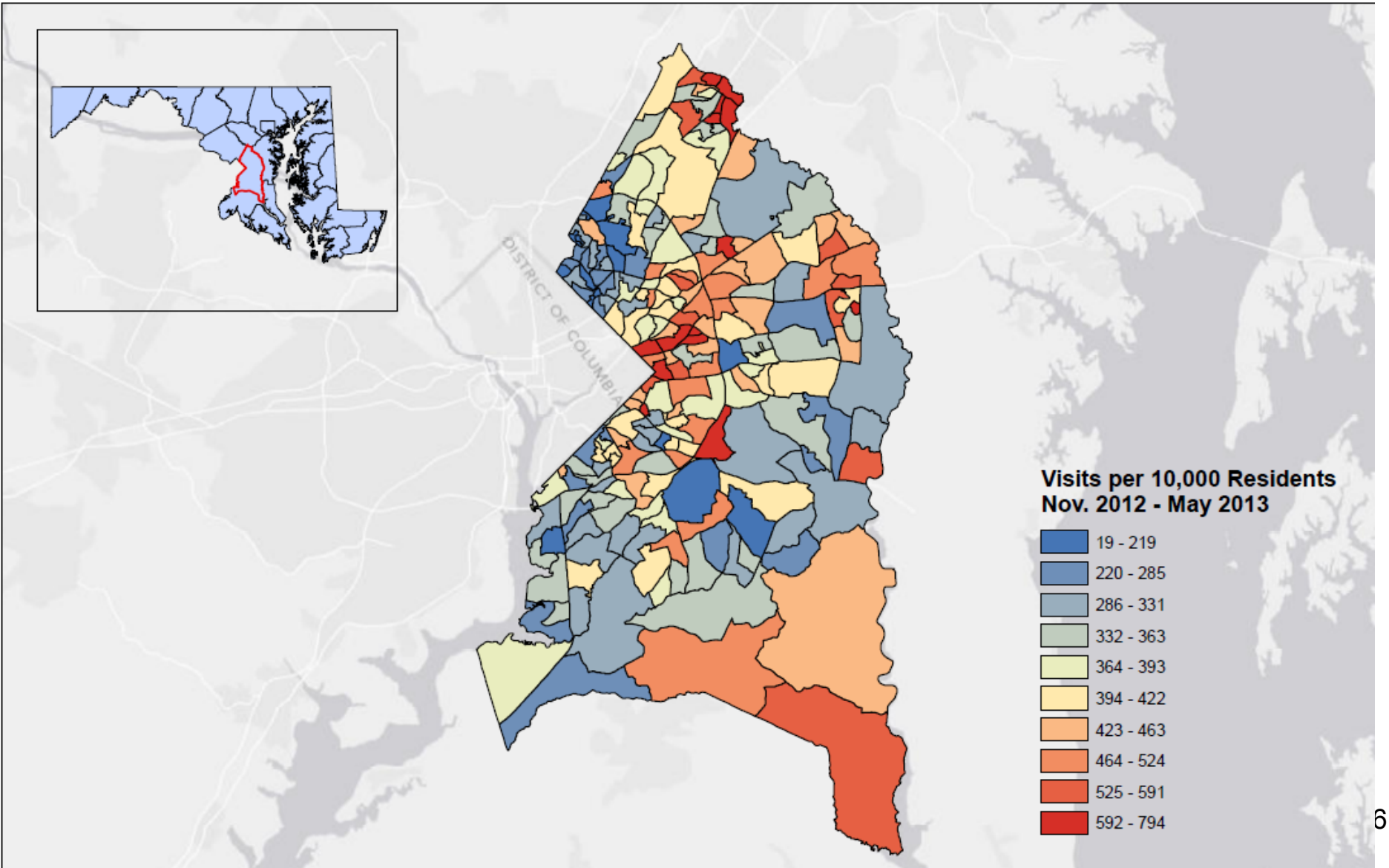

In-Patient Bed Days – Prince George's County

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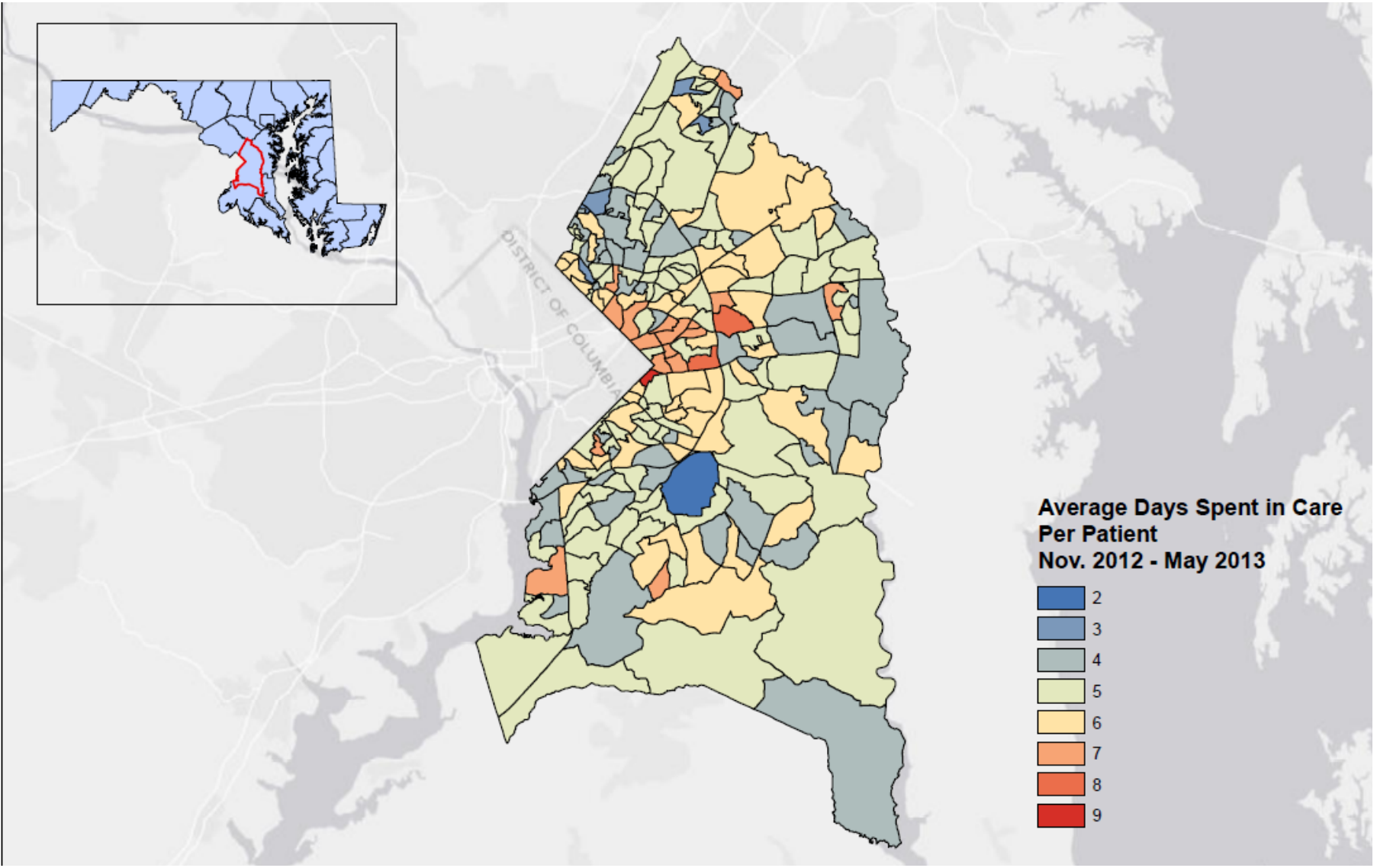
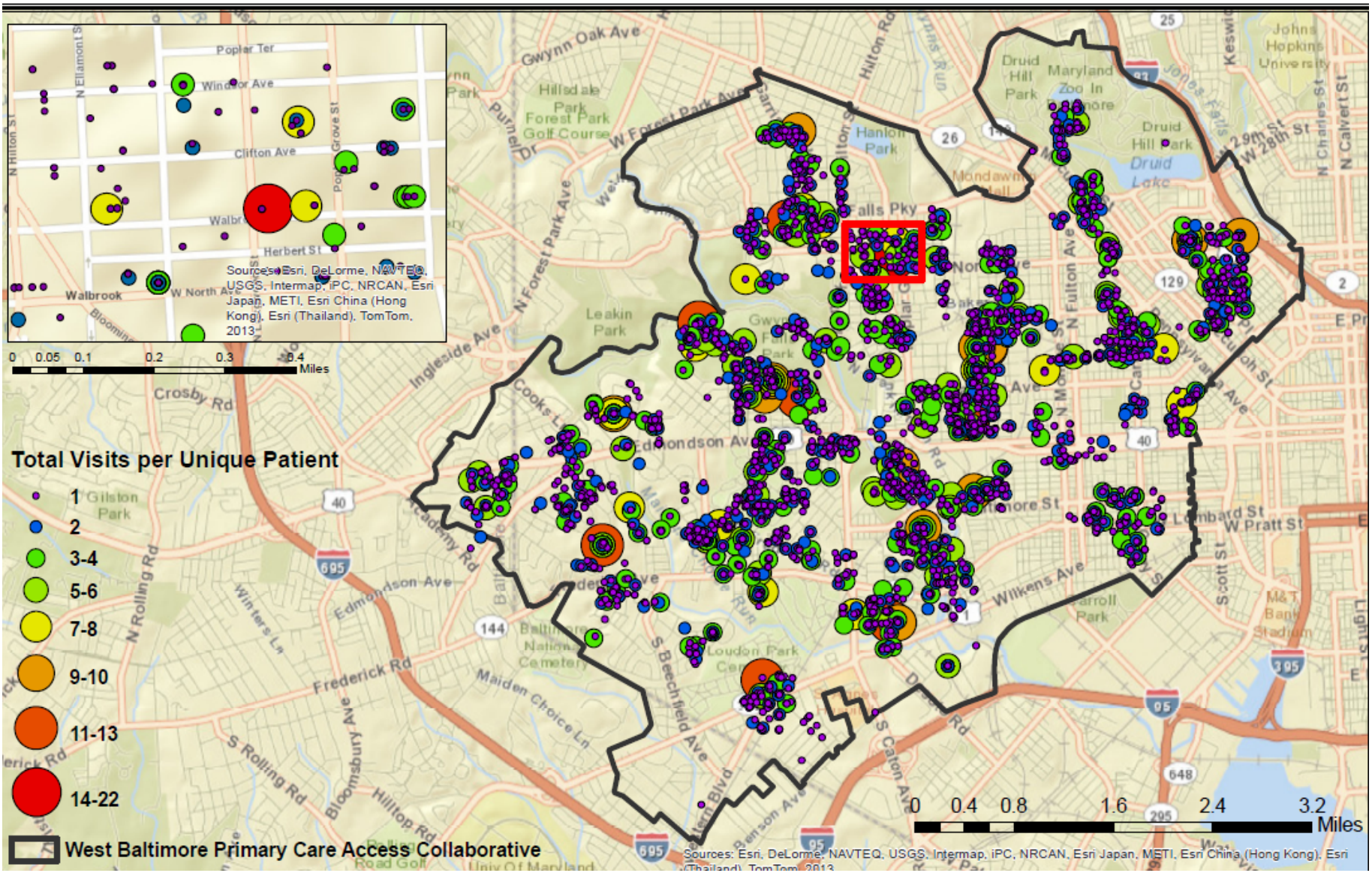


Patient Level IP Utilization – West Baltimore (Example)

Chesapeake Regional Information System for Our Patients



Scott Afzal
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LHICs

LHIC Certification, Function, and Structure

- Certification: Public Utility will certify participating primary care practices as well as LHICs based on an established criteria.

- Function: Determining the core functions of the LHIC will be critical to developed certification criteria. LHIC may be responsible for oversight of functions but may not directly execute each function. LHIC may wish to partner with existing organization to conduct a specific function.

- Structure: LHICs structure may vary based on context, geography, population, existing community collaboration and resources. However, criteria for certification will be standardized.

Expanding Local Health Improvement Coalitions (LHICs) Role

LHIC role as the population health integrator will include core functions:

- ✓ *Prioritization of population health needs (SHIP measures)*
- ✓ *Convening/facilitating partnerships to address population priorities*
- ✓ *Performance monitoring*
- Continuous quality improvement to hit cost and quality targets
- Data analytics and aggregation
- Hiring and deploying CIMH workforce

Community Care of North Carolina

Legend

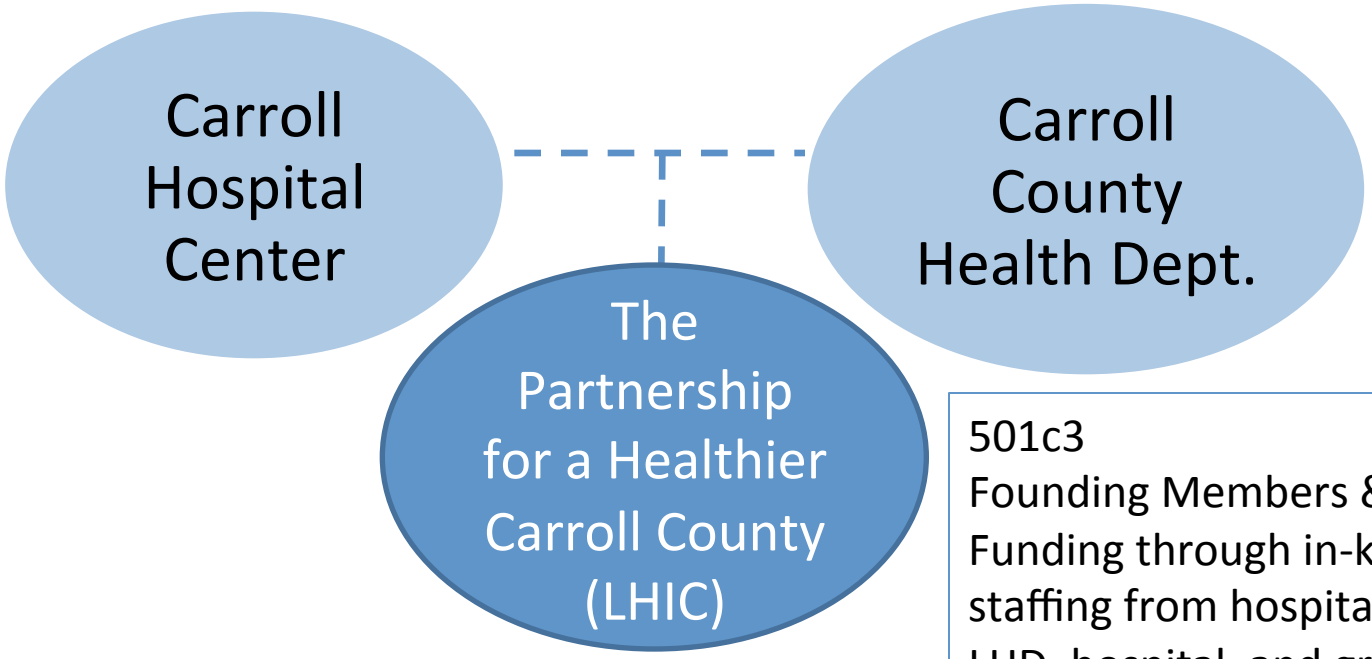
- AccessCare Network Sites
- AccessCare Network Counties
- Community Care of Western North Carolina
- Community Care of the Lower Cape Fear
- Carolina Collaborative Community Care
- Community Care of Wake and Johnston Counties
- Community Care Partners of Greater Mecklenburg
- Carolina Community Health Partnership
- Community Care Plan of Eastern Carolina
- Community Health Partners
- Northern Piedmont Community Care
- Northwest Community Care
- Partnership for Community Care
- Community Care of the Sandhills
- Community Care of Southern Piedmont

Source: CCNC March 2013

Community Care Networks – North Carolina

- Population Management Tools
- Case Management and Clinical Support
- Data Measurement and Feedback
- Quality Improvement

Emerging Maryland Examples: Carroll County



501c3
Founding Members & BOD
Funding through in-kind staffing from hospital and LHD, hospital, and grants

Roles/Functions of the Partnership:

- Conduct Community Needs Assessment – to address unmet need
- Prioritize & identify target populations
- Allocate grant resources to direct service organizations
- Serve as a collaborative vehicle for interaction with the community
- Expand capacity health and quality of life improvement
- Monitoring health status of the community

Expanding Local Health Improvement Coalitions (LHICs) Role

LHIC role as the population health integrator will include core functions:

- ✓ *Prioritization of population health needs (SHIP measures)*
- ✓ *Convening/facilitating partnerships to address population priorities*
- ✓ *Performance monitoring*
- Continuous quality improvement to hit cost and quality targets
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- Hiring and deploying CIMH workforce

Key Questions for LHIC Development

- Are these the appropriate functions for the expanded role of the LHIC to support CIMH?
- What does the certification of LHIC look like?
- How will LHICs leverage the functions of existing organizations that have core competencies to meet the expanded LHIC role?
- How does the LHIC have to structurally change to meet the new expanded role of the LHIC proposed here?
- Is there a tiered approach to readiness for the LHICs?

Questions or Comments?

Getting to Version 2.0 of Maryland's State Health Innovation Plan

Revised Timeline

- CMS will be considering requests for < 2 month extension
- All-Stakeholder Summit rescheduled for **September 10, 2013**

Model Refinement through Concentrated Stakeholder Input

- Establishment of workgroups to provided targeted feedback on key areas of SIM model design
  - Governance
  - Payment model
  - Participation standards
  - The role of the LHICs
  - Phasing in implementation
- Wiki process to solicit feedback
  - August 10 – Wiki released
  - August 19 – feedback due

Maryland SIM Wiki – Online Collaborative Design

A website developed collaboratively by a community of users that allows users to add and edit content

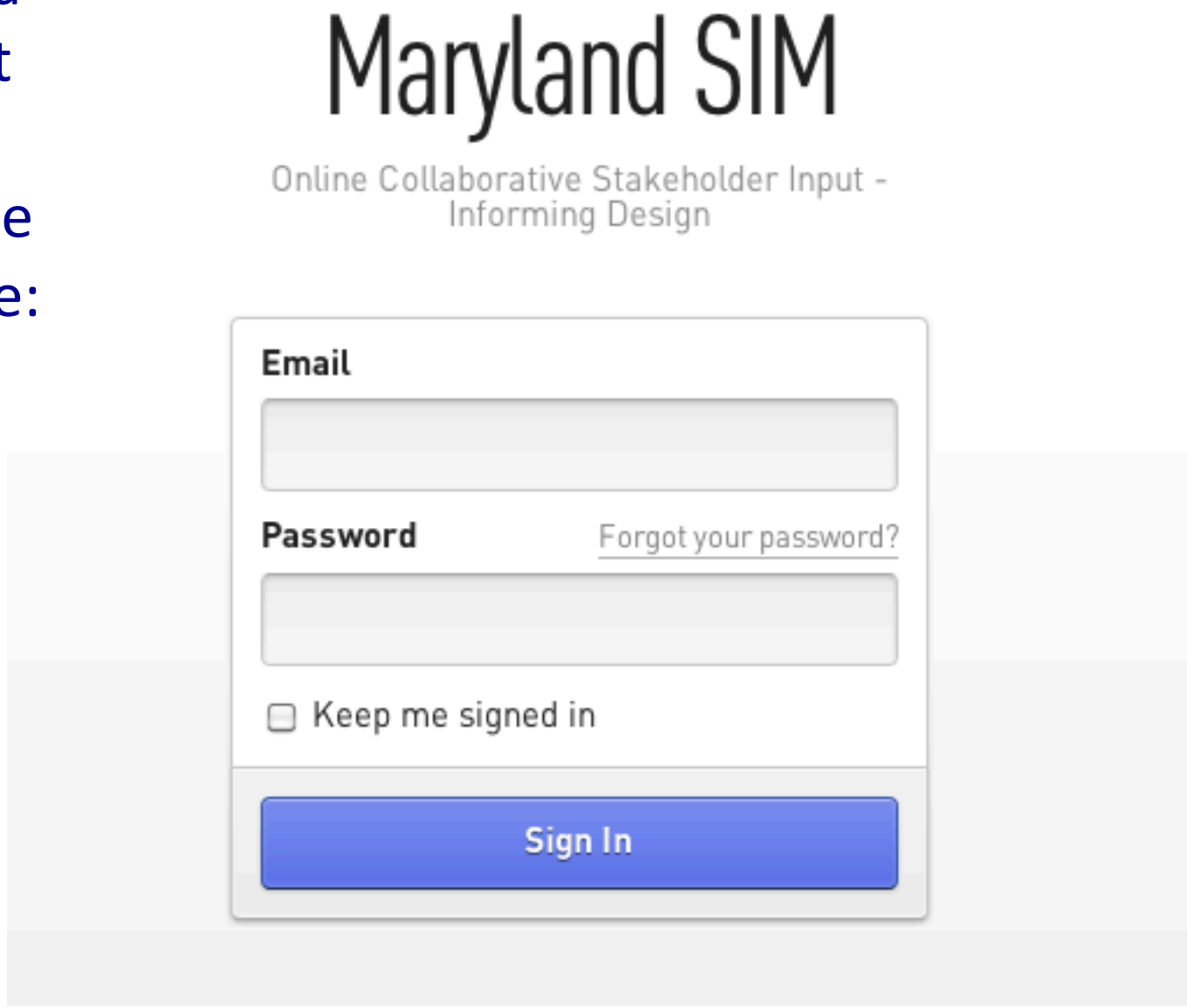
Why experiment with this?

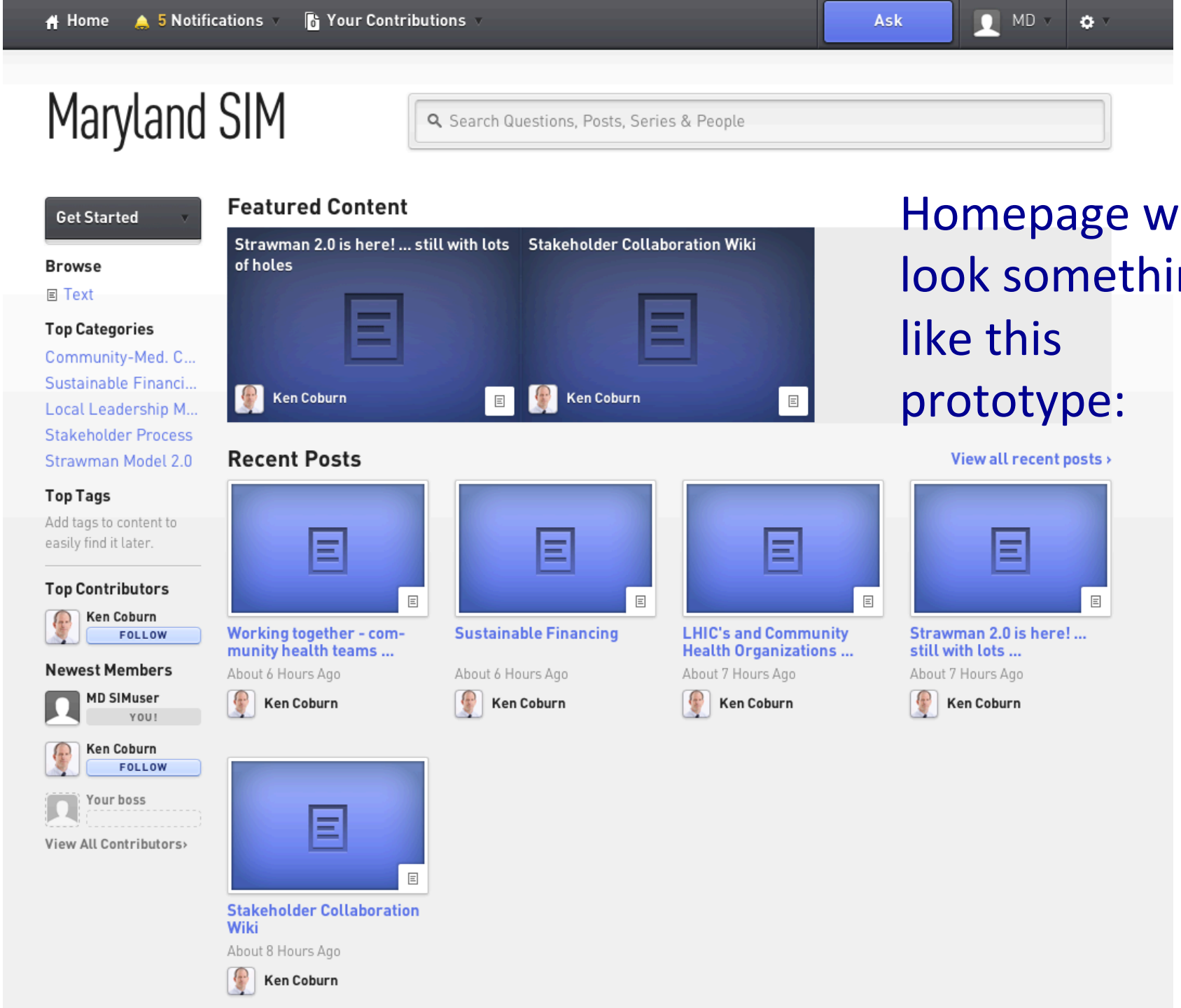
- Still a lot of missing parts to the model that need more stakeholder input
  - We hope this will help us solicit and organize feedback needed to address specific areas requiring more thought and input
- Asynchronous online input is accessible whenever it's convenient for users
- Threads of comments and responses shared among users stimulates thinking and idea generation
- Will help us pull together Strawman model x.0 for the Summit in September!

SIM Online Collaborative Design

- Website currently undergoing set-up and testing
- Hosted by a service used by HQP and co-managed with DHMH
- Open to SIM Stakeholder participants
  - Login with username/email and user selected password
- Will be a professional/social environment with simple ground rules
  - Comments will be monitored periodically, but will not require approval before posting; VISIBLE TO ALL SITE USERS
  - Creating new pages (starting a new topic thread) will probably require site management approval before being published to the site
  - Respect for all users and contributions; SIM use only; proper decorum
- Information about signing up and using the site will be sent to you by email in the coming weeks

Login will be a webpage that looks something like this prototype:





Homepage will look something like this prototype:

Home | 5 Notifications | Your Contributions | Ask | MD

Maryland SIM

Search Questions, Posts, Series & People

Stakeholder Collaboration Wiki

CONTRIBUTED BY
Ken Coburn

Hi-Five

Follow Post

+

Keep those ideas and suggestions coming! Along with the continued professionalism, mutual respect, and decorum that has been the hallmark of our in-person stakeholder meetings. Remember that your fellow stakeholders, Maryland Department of Health staff, and members of the HQP team, and other consultants can see the comments you

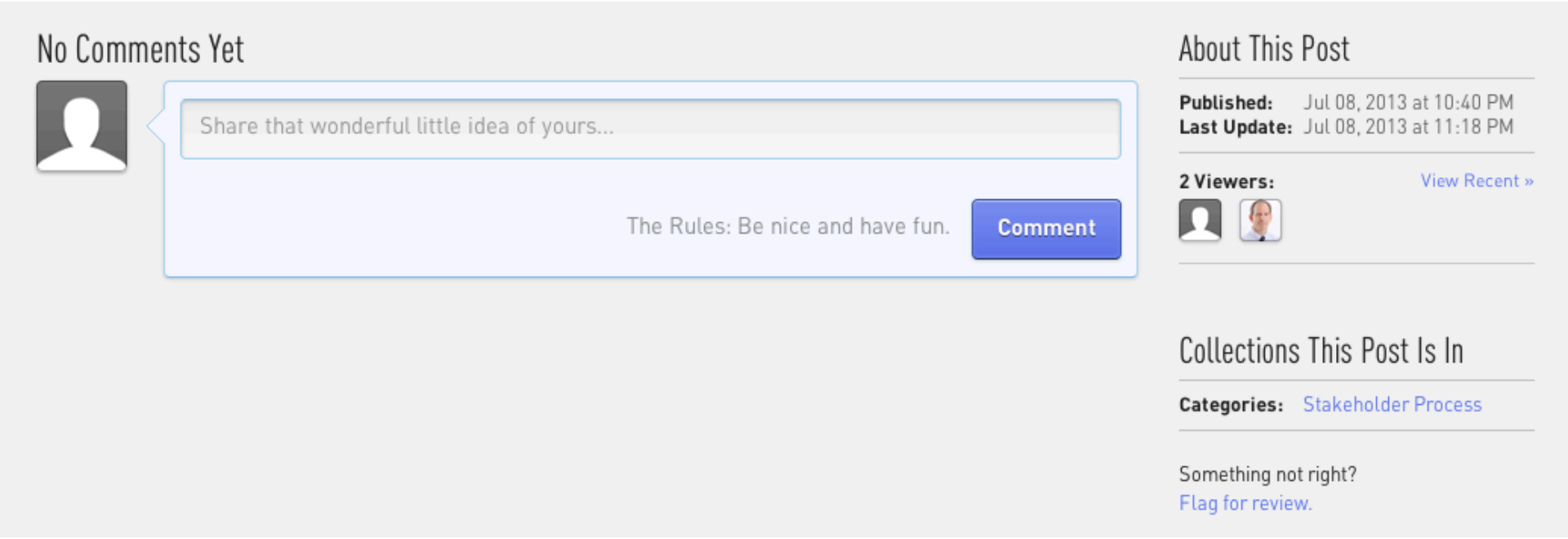
A page posting that defines a topic will look something like this prototype:

In the spirit of ongoing collaborative design, HQP seeks to foster continued stakeholder input - in this online, wiki-like community. Log in whenever it's convenient, try a few of the option settings to be notified of changes, and enjoy! We greatly appreciate and look forward to your continued contribution to designing a better health system for Maryland. I also value your suggestions for making this stakeholder design process more meaningful and effective.

Thanks,

Ken

Comment box used to share your ideas and feedback about a topic (at the bottom of that page/ thread), will look something like this prototype:



Thanks!

- More information will be coming to your email inbox in the next few weeks
- We greatly appreciate your time and willingness to give this a try
- We welcome your feedback on how this is working & ways to improve, once we go live
  - Ken Coburn coburn@hqp.org
  - Sherry Marcantonio marcantonio@hqp.org

Questions or Comments?

New Date For SIM Summit

All-Stakeholder Summit rescheduled for

September 10, 2013

Please save the date!